Learning lessons about self-neglect? An analysis of serious case reviews

Article (Unspecified)

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Introduction

In England and Wales Local Safeguarding Adults Boards (LSABs) are not required to conduct or publish serious case reviews (SCRs). Many have adopted guidelines published by the Association of Directors of Social Services (ADSS, 2005) but these are only advisory. Consequently, some uncertainty remains on what circumstances should trigger such reviews and practice is variable in the absence of central government guidance on thresholds, inter-agency co-operation, resourcing, media management, timescales and publication (Manthorpe and Martineau, 2012). No database exists of commissioned and published SCRs, which makes collation and analysis to facilitate learning and practice development difficult (Braye et al., 2011; Manthorpe and Martineau, 2011). Those SCRs that *are* published, however, if only in executive summary form, can cast considerable light on safeguarding practice.

The Care Act 2014, which reforms adult social care and adult safeguarding law in England and Wales, places a duty on LSABs (henceforth constituted on a statutory basis) to carry out and publish safeguarding adult reviews where serious abuse or neglect has contributed to the death or serious harm of an individual, and where there is reasonable cause for concern about how professionals and agencies have worked together. LSABs will also have a power to undertake reviews in other circumstances, the purpose throughout being to learn lessons and improve future practice. This responds to the need to learn from challenging cases and to channel that learning from individual incidents into the wider service context and professional network in order to improve standards and governance (Brown, 2009).

One of the key challenges in adult safeguarding is ensuring the wellbeing of adults where risk arises from self-neglect rather than from a third party, particularly where they do not wish to engage with the state's protective agenda. Research has identified that health and social care professionals often find self-neglect cases of this kind to be enormously challenging and fraught with ethical and legal dilemmas, particularly when adults are judged to have mental capacity to refuse support (Braye et al., 2011; 2013). Practitioners report feeling exposed when coping with disappointments and anxiety, and uncertain how to balance a duty of care with a person's right to private life. Organisational systems may not clearly locate strategic responsibility for complex cases that require flexible, multi-professional interventions, or facilitate effective practice, which resides in the ability to build relationships over time, to balance concerned curiosity with respect and persistence, to routinely assess mental capacity and to evaluate possible legal options (Braye et al, 2014). Maximising sources of learning is therefore essential. Self-neglect is complex and diverse. In England and Wales there is no standard definition and, currently, cases of adults who self-neglect fall outside the statutory guidance on adult safeguarding, which requires third party involvement in abuse and neglect (DH, 2000; Welsh Government, 2000). Despite this, where adults who self-neglect have died or suffered significant harm LSABs have sometimes commissioned SCRs, but those that have been published have not been collated or analysed hitherto.

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This article presents the first analysis of available SCRs involving cases of adults who self-neglect. It provides an index of materials that has utility for adult social care and broader safeguarding networks, including practitioners, managers and trainers. Lessons for single and multi-agency practice are identified, and implications for legislation and public policy also emerge. Self-neglect for definitional purposes in this paper, drawing on the literature and practice (Braye et al., 2011 ; 2013), centres on:

- lack of self-care – neglect of personal hygiene, nutrition, hydration, and health, and/or
- lack of care of one's environment – squalor and hoarding, and/or
- refusal of services that would mitigate risk of harm to safety and well-being.

Serious case reviews in the adult safeguarding literature

The purpose of SCRs is not to apportion blame or establish culpability but to learn and implement lessons from a case about how agencies and professionals worked together. The purpose is also to disseminate examples of good individual practice and effective inter-agency working. Typically a chronology of events will be compiled and terms of reference set. The agencies involved will produce individual management reports, written by someone not involved in the substantive case, which will then be drawn upon by a commissioned overview report writer who produces the SCR and Executive Summary. At their best SCRs are quality improvement tools, to be drawn upon for learning and service improvement, but they can be compromised by variable standards of analysis and by lack of inter-agency engagement.

To date there has been limited discussion in adult safeguarding literature on SCRs with respect to: what methodologies of inquiry might be useful; whether they should be published in part or in full; what can helpfully be extrapolated from what are, quite possibly, exceptional case studies; and when alternative audit approaches might be more appropriate. Brown (2009) has suggested that different methodologies might be required in response to the various complexities these cases contain. Manthorpe and Martineau (2011; 2012) have observed that it is difficult to know the rationale behind decisions whether or not to commission an SCR and they have recommended a clearer differentiation between SCRs and other investigative mechanisms, such as serious untoward incident inquiries in the NHS.

The adult safeguarding literature has, nonetheless, been concerned with the dangers of simply replicating the process overseen by Local Safeguarding Children Boards. For example, warnings have been sounded about adopting an overly prescriptive, template approach (Flynn et al., 2011). Brown (2009) and Manthorpe and Martineau (2012) have drawn attention to the tension when conducting SCRs between holding individual practitioners and agencies to account, which can result in disciplinary procedures being invoked, and seeking to maximise learning for practice and organisational development by encouraging practitioners and managers to be open about what influenced their decision-making. Scourfield (2010) offers a critique of one SCR, but hitherto detailed questioning of the standards of SCRs has been rare. Aylett (2008) has questioned whether continued reliance on SCRs produces any new learning. Manthorpe and Martineau (2013) observe that SCRs

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have potential as learning materials, though learning may take time to emerge, but counsel against seeing them as presenting a full picture of practice.

In this context, consideration of groups of SCRs, identifying common or diverse themes, extends the learning that can be extracted from individual reports and strengthens their contribution as an important resource for legislative, policy, service and practice development. Manthorpe and Martineau's (2013) focus on learning disability within SCRs is one example; another is Parry's review of reviews (2013) investigating the role of housing providers in adult safeguarding. A further focus has been upon the learning to be gained from focusing on SCRs undertaken in one particular geographical location, as with Bestjan's (2012) overview of SCRs in London Boroughs.

Methodology

In the present study of SCRs in cases of self-neglect, the following research questions were identified at the outset:

1. What was the nature of the self-neglect cases reviewed through SCR processes?
2. What themes emerged from the SCRs and how do these add to understanding about professional intervention in cases of self-neglect?
3. How many and what kind of recommendations on self-neglect were made by SCRs and to which agencies were they addressed?

The study originated within research into the workforce development needs of social care staff working with self-neglect. SCRs not infrequently recommend staff training, and the researchers were curious to identify whether training needs had been identified in reviews of self-neglect cases. Themes from SCRs identified in that preliminary internet search of a sub-sample of LSAB web-pages have been reported (Braye et al., 2013), but in the light of the value of those early findings a more comprehensive search and in-depth analysis then took place. In the absence of any existing comprehensive source of consolidated data, the researchers, as in Manthorpe and Martineau's study (2013), undertook a systematic internet search of all English local authority and LSAB web pages (n = 153) to locate published SCR summaries. Initial screening of available executive summaries identified SCRs (n=22) where self-neglect had been either a central or a more peripheral feature. Further SCRs and two instances of lessons learned case reviews[i], not necessarily in the public domain, were identified through contacts with participants in the workforce development needs study, and through the network of Independent Chairs of LSABs. These supplementary approaches enabled further reviews (n=10) to be retrieved for analysis. Altogether 40 SCRs were identified as having taken place or been commissioned, with 32 of these available, to the researchers, in executive summary or occasionally longer formats, for detailed analysis.

Ethical approval for the workforce development study was secured (University of Sussex Social Science and Arts REC, ER/SB210/1). As with Manthorpe and Martineau (2013), in order to reduce risk of distress from the use of material in the present analysis, cases already in the public domain have been referenced here as reported in the SCRs, but without using full names of individuals even

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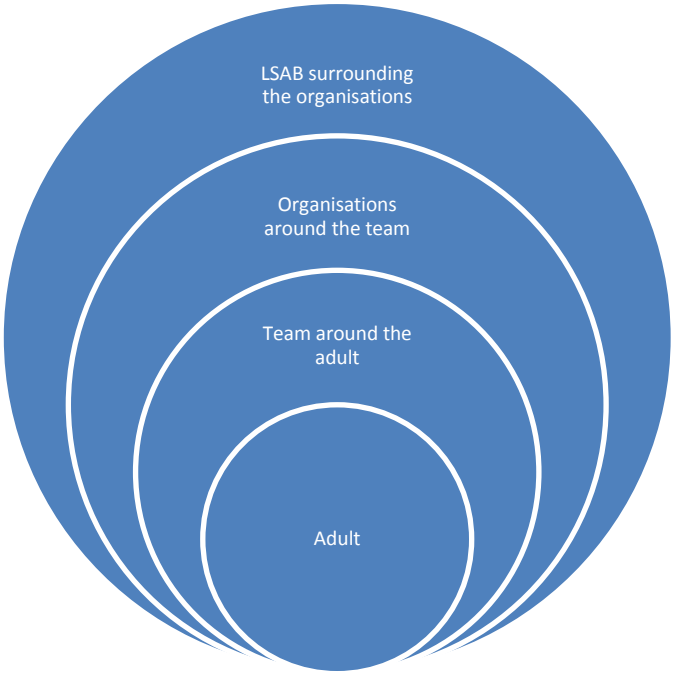
where those are publicly available. Where use has been made of unpublished material, the anonymity of the authority in question has been respected and certain details withheld to preserve confidentiality.

The methods used for reading, analysing and making sense of the reviews and their recommendations were adapted from a study of SCRs in children's services (Brandon et al., 2011). The approach taken responded to the variability of completeness in the data available from the reviews, which ranged from full reports to executive summaries of varying length with little commonality of format. Initially a four-layered analysis was conducted, namely:

1. Key characteristics of each case (n=40): gender, ethnicity, age, domestic living status, disability, details of agency involvement;
2. Key characteristics of the SCRs (n=40): publication, length, whether self-neglect comprised a central dynamic, number of recommendations, availability of action plans;
3. Frequency of recommendations in the SCRs (n=32) for individual agencies and for LSABs;
4. Themes extracted from the recommendations in the SCRs (n=32).

Subsequently, a second, cross-case approach was taken with respect to themes contained within the reports and recommendations. This utilised a framework that worked outwards from the adult who self-neglects to incorporate the team around the adult, the organisations around the team, and the LSAB around the organisations. The focus was on what was seen as representing good practice in the different domains, as captured in Figure 1.

Figure 1: A layered approach for good practice emerging from recommendation themes



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Since SCRs currently do not have to be published or, indeed, referenced in LSAB annual reports, it is difficult to determine what the sample of 40 reports identified represents as a proportion of all SCRs commissioned and/or completed in self-neglect cases. References to SCRs, lessons learned and exceptional case reviews were found on occasion in LSABs' published annual reports, without being available on the website and with insufficient detail available to determine the exact nature of the issues in question. One LSAB Business Manager who participated in research to explore the evidence-base for effective work with adults who self-neglect (Braye et al., 2014), commented that "*we've had more serious case reviews [here] of individuals who have died of self-neglect than we have of safeguarding, which is quite telling*." In the same research study, two interviewees referred to learning events that had been held involving self-neglect cases. When contributing to the SCR sample for the present paper, individuals sometimes mentioned that a review had been conducted but not published in order to spare distress to family members. From the LSABs within the sample, some had only commissioned reviews involving cases of self-neglect; for some others, self-neglect SCRs formed a sizeable proportion of commissioning activity. It is likely, therefore, that more reviews have been undertaken but remain solely available to the commissioning LSAB.

There is some overlap with SCR studies focusing on other groups. Of Manthorpe and Martineau's (2013) sample of 18, drawn from a wider collection of 75 reports, three are replicated in this analysis. In an earlier paper, Manthorpe and Martineau (2011) list 22 SCRs but it is difficult to cross-refer their sample to this study because of their protection of identities. None of the cases in that sample are, however, described as having involved self-neglect. Parry's review of SCRs involving housing issues draws on 15 reports, six of which are replicated here. Finally, Clay (2013) has collated 50 reports of which fifteen are also contained in this sample of self-neglect cases. Thus, self-neglect is only one of a complex array of issues that may be examined through a review process.

Clearly, self-neglect cases comprise a sizeable sub-group of commissioned SCRs. Whether or not such cases should come within the umbrella of adult safeguarding rather than social and community care (Scourfield, 2010), they raise significant ethical, legal and practice questions revolving around self-determination, risk, duty of care and protection, and illustrate how the need for SCRs and discussion of self-neglect cases has grown because of the complex and multi-layered mandates and systems that are engaged. The present sample provides further evidence that self-neglect is a strong feature within SCRs.

Findings

Initial four-layered analysis

Layer one: key characteristics of the case

Key service user characteristics contained within the SCR sample are summarised in Table 1. Where known (n = 37), 54% of the sample are male and 46% female. Where age was known (n = 28), the largest group were over 76 (39%); 18% of the sample were aged between 21 and 39, 29% between 40 and 59 and 14% between 60 and 75. Ethnicity was not routinely recorded in the reports, as

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Manthorpe and Martineau (2011) also found. As Scourfield (2010) observed, the published reports do not always give exact details of how the individuals concerned died. In 34 cases it was possible to discern the type of self-neglect. Lack of self-care was present in 24 cases, lack of care of one's environment in 16 and refusal of services in 29. All three elements were present in 11 cases.

Table 1: Key characteristics of the individual showing self-neglect

Case Number	**LSAB, Date, Case Name**	**Gender, Age**	**Living Situation**	**Circumstances Where Known**
1	Dudley (2010), AC	Male, 73	Lived alone	Health concerns. Alcohol abuse. Died at a bus shelter after requested hospital discharge
2	Dudley (2010), BD	Male, 39	Lived alone	Alcohol abuse. Anti-social behaviour. Found dead at home
3	Nottinghamshire (2010), Adult E	Female, 40	Lived alone	Physically disabled. Died in hospital of multi-organ failure
4	Sheffield (2010), Ann	Female, mid 40s	Lived alone after divorce & child taken into care	Physically disabled. Died at home of pyelonephritis, urine infection and kidney stones
5	Cornwall (2007), Adult Female	Female, 43	Lived alone	Died in hospital of infected fracture & alcoholic liver disease
6	Cornwall (2009), JK	Female, 76	Lived alone	Undefined health needs. Died at home
7	Surrey (no date), 0002	Female, 81	Lived alone, with visits from her children, since husband's death	Mild to moderate dementia. Died in a house fire
8	Southampton (2012), Mr A	Male, 49	Supported living; some contact with brothers	Learning disability, epilepsy and scoliosis. Died at home from natural causes, a combination of dehydration, colitis and epilepsy
9	Birmingham (2010), A1	Male, 34	At home with parents and siblings	Learning disability and mental health issues. Died in hospital of septicaemia, gangrene, poor nutrition and hospital acquired pneumonia
10	Birmingham (2012), A2	Male, 78	Care and nursing home; contact with sons and daughter	Dementia, arterial disease and type two diabetes, also mental health concerns
11	Warwickshire (2010), GH	Female, 27	Own tenancy with floating support worker	Conflicting diagnoses of learning disability and autistic spectrum disorder. Murdered
12	Worcestershire (2010), A1	Male, 58	Own accommodation but also lived	Died at home of pneumonia, paranoid schizophrenia and inanition

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			with his mother	
13	Bath and North East Somerset (2011), Ms A (deceased)	Female, not given	Nursing home placement	Mental health concerns and learning disability. Died of bowel complications
14	Gloucestershire (2012), Adult X	Male, not given	Lived alone; contact with son	Died in a house fire
15	Torbay (2011), Ms Y	Female, 30	Not specified; some contact with mother; reported missing before her death	Liver failure due to alcohol dependency; evidence of physical assaults
16	North Yorkshire (2012), Robert	Male, not given	Found emergency accommodation after rough sleeping	Physically disabled. Died in a hotel room from morphine intoxication
17	Westminster (2011), Mr BB	Male, 86	Lived with his wife	Mental health concerns, dementia and hypothyroidism. Died in hospital of pneumonia
18	Kent and Medway (2003), Case D	Male, 27	Lived with parents	Physical and learning disabilities. Died in hospital of uncontrolled fitting
19	Kent and Medway (2013), Mr J	Male, not given	Lived alone	Alcohol issues. Diagnosis of Alzheimer's. Died in hospital from multiple injuries
20	Bournemouth (2010), Mrs A	Female, 83	Lived alone	Murdered by her son-in-law
21	Dorset (2012), JT	Female, not given	Lived with husband	Range of health related concerns. Died in care home of stroke
22	A Council (2011a), Withheld	Male, older person	Shared accommodation	Mental health issues. Died at home
23	A Council (2011b), Withheld	Female, older person	Lived alone; little family contact	Physical illnesses associated with older age. Admitted to hospital and then care home; health and well-being improved
24	Sheffield (2008), AL	Female, 74	Lived with son	Died of bronchopneumonia, ulcers and chronic obstructive pulmonary disease
25	Brighton and Hove, Not known	Not known	Not available	Not available
26	West Sussex (2009), Not released	Not known	Not available	Died at home
27	West Sussex (2010), Not released	Not known	Not available	Died at home
28	Suffolk, Not known	Male, not known	Lived alone	Died in a fire at home

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29	Newham, RS	Male, 56	Lived alone	Died in hospital
30	B Council (2014), X	Male, 82	Lived alone but contact with family	Mental health issues. Died in hospital following fire at home
31	B Council (2013), CC	Male, 58	Lived alone	Mental health concerns. Alcohol issues. Died in hospital of burns from fire at home
32	Waltham Forest, Not released	Male, 74	Lived alone	Died at home; open verdict
33	Leeds (2009), Mrs P	Female, 83	Lived alone	Medical conditions. Limited mobility. Died in a house fire
34	Northamptonshire (2010), Mr & Mrs R	Male, 77; Female, 79	Married couple	Died at home of pneumonia and lung cancer/cardiac failure & chronic obstructive pulmonary disorder
35	North Tyneside (2011), Adult A	Female. 59	Lived with her brother	Learning disability and diabetes. Died in hospital of hypothermia
36	Lambeth (2012), Mr A	Male, 63	Lived alone	Mental health diagnosis. Died sleeping rough
37	C Council (2010), Adult A	Female, 80	Lived with her disabled son	Died in hospital of natural causes aggravated by self-neglect
38	C Council (2012), Mr B	Male, not known	Lived alone	Mental health concerns. Died in hospital of pneumonia & chronic obstructive pulmonary disease
39	Slough (2013), DD	Female, 99	Lived alone	Died at home of myocardial infarction, hypertension & dementia
40	D Council, Not known	Not known	Married	Wife died in a care home

Layer two: key characteristics of the SCR

Table Two summarises key characteristics of the SCR sample. Within the 32 reports available, the focus on self-neglect has been deemed central (n=14) where it is explicitly fore-grounded in the analysis and in the recommendations. The focus has been termed implicit (n=12) where self-neglect is not named as such but may be discerned from the description of the circumstances of the case; and peripheral (n=6) where self-neglect has been named but backlit, rather than seen as the central component of a case.

Manthorpe and Martineau (2011), in reviewing their SCR sample, observed that it is rare for inquiry methods to be laid out and for the procedures followed to be detailed. They have also suggested (2012) that an independent chair of the SCR panel, set up to oversee the process, may improve quality, encourage better agency responses, command more public confidence in the process and findings, and more effectively manage complex relationships when particular organisations are under scrutiny. In the present sample, the SCR authors are sometimes anonymous. Some SCR panels were independently chaired but it is impossible to ascertain from published reports what effect, if

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any, this arrangement may have had on process or outcome. Equally, it is not routinely clear which agencies were represented on an SCR panel that oversaw the process, nor how the information was collated and the reports written. There is considerable variation in length: executive summaries ran between 5 and 49 pages; where the full report was available, the length varied between 21 and 63 pages. There is similar variation (between 4 and 30) in the number and detail of the recommendations. This variation may reflect the gradual development of methodologies for conducting such SCRs and of expertise in report writing, the shortage of available guidance and/or the challenge of securing agency engagement and resources. The nature of the sample therefore raises questions about the transparency of the process and influences the weight that can be placed on report findings.

Diverse conclusions are reached by different LSABs regarding publication of the findings/ recommendations and dissemination of the learning. For example, case 29 is described in an annual report (Newham, 2010) as having involved the individual's admission to hospital with very low weight, indicative of poor nutrition and starvation. The person had been receiving some statutory services but the decline of their physical and mental health had not been picked up. This case could include aspects of self-neglect but the SCR has not been published and subsequent annual reports do not refer to the case. Some cases have not been published because of agreements reached with the families about protection of their identities. Nonetheless, the findings have been presented at professional conferences, and/or used to develop or review multi-agency procedures for the management of cases where adults self-neglect (Slay, 2010). Brown (2009) has acknowledged the struggle with how best to place learning into the public domain without compromising confidentiality and the integrity of individuals and partner agencies. The absence of a statutory requirement in England and Wales on agencies to co-operate with an SCR may aggravate that struggle (Brown, 2009), but implementation of the duties to cooperate and to share information (Care Act 2014) should bring improvements here. Others have suggested that there is scant evidence that lessons are disseminated effectively at local organisational levels or more widely (Flynn et al., 2011).

Table 2: Layer Two – Key Characteristics of Sample SCRs

Case Number	LSAB, Author, Date	Published, Nature of document, Length	Self-Neglect Focus	Number of Recommendations
1	Dudley: Reader (2010)	Published, Executive summary, 7 pages	Central	None but 16 key issues identified for an action plan
2	Dudley: Coe (2010)	Published, Final Report, 12 pages	Implicit	7
3	Nottinghamshire (2010)	Published, Executive summary, 19 pages	Central	17
4	Sheffield: Flynn (2010)	Published, Executive summary, 14 pages	Central	9, with a further 7 sub-elements
5	Cornwall(2007)	Published, Executive summary, 9 pages	Implicit	11
6	Cornwall (2009)	Published, Executive	Central	4, with a further 8

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		summary and action plan, 19 pages		sub-elements
7	Surrey: Sexton and Lawson (no date)	Published, Executive summary, 16 pages	Peripheral	19
8	Southampton: Allured (2012)	Published, Executive summary, 14 pages	Implicit	9
9	Birmingham (2010)	Published, Executive summary and action plan, 10 pages	Peripheral	9
10	Birmingham: Lawson (2012)	Published, Executive summary, 15 pages	Peripheral	13
11	Warwickshire: McAteer (2010)	Published, Serious Case Review, 63 pages	Central	26, some with multiple elements, 6 broader and 3 national issues
12	Worcestershire (2010)	Published, Executive summary, 8 pages	Central	8
13	Bath and North East Somerset (2011)	Published, Summary report, 8 pages	Peripheral	6
14	Gloucestershire (2012)	Published, Executive summary, 12 pages	Implicit	15
15	Torbay: Hinks and Craddock (2011)	Published, Executive summary, 11 pages	Implicit	11, with 17 sub-elements
16	North Yorkshire: Wilson (2012)	Published, Executive summary, 22 pages	Implicit	13
17	Westminster: Lawson (2011)	Published, Executive summary, 49 pages	Central	11
18	Kent and Medway (2003)	Published, Executive summary, 5 pages	Implicit	12 with 11 action plan points for agencies
19	Kent and Medway: Harrington (2013)	Published, Executive summary, 8 pages	Peripheral	9
20	Bournemouth: Whatley (2010)	Published, Executive summary, 8 pages	Implicit	20
21	Dorset (2012)	Published, Executive summary, 7 pages, Overview report, 51 pages	Implicit	11
22	A Council (2011)	Not published, 10 pages	Central	13
23	A Council (2011)	Not published, 19 pages	Central	18 key findings, 6 conclusions and 30 single or multi-agency recommendations
24	Sheffield (2008)	Not published, 13 pages	Central	4, with 12 sub-elements

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25	Brighton and Hove	Not published	Not available	Not available
26	West Sussex (2009)	Not published	Not available	Not available
27	West Sussex (2010)	Not published	Not available	Not available
28	Suffolk	Not published	Not available	Not available
29	Newham	Not published	Not available	Not available
30	B Council	Commissioned	Not yet known	Not yet available
31	B Council (2013)	Not published, Case review report, 8 pages	Central	11
32	Waltham Forest	Commissioned	Not yet known	Not yet available
33	Leeds: Muir (2009)	Published, Executive summary, 15 pages	Implicit	14
34	Northamptonshire: Johnson (2010)	Published, Executive summary, 13 pages	Implicit	8
35	North Tyneside: Wood (2011)	Published, Final report, 26 pages	Implicit	8
36	Lambeth (2012)	Published, Executive summary, 14 pages	Central	9
37	C Council: author withheld (2010)	Not published, SCR overview report, 54 pages	Central	23
38	C Council (2012)	Not published, Multi-agency review, 11 pages	Central	None but 3 areas for consideration
39	Slough: Lawson (2013)	Published, Executive summary, 9 pages	Peripheral	12
40	D Council	Lessons learned review not yet completed	Not yet known	Not yet available

Layer three: recommendations

In the 32 SCRs for which an executive summary and/or full or overview report was available, recommendations were addressed to both LSABs and individual agencies. Table Three identifies the agencies to which recommendations were addressed and their frequency. A very high proportion of reports (81%) contained recommendations for the LSAB itself, with adult social care also targeted in well over half (69%). Particularly noteworthy in terms of potentially compromising the impact of reviews on practice was the number of recommendations where it was not possible to identify the healthcare organisation (in 5 reports) or other agency (in 22 reports – 69%) charged with taking forward particular actions, although it is recognised that the full but unpublished versions of the reports may be more specific and therefore engage greater accountability. Frequently recommendations were directed simultaneously at a number of agencies and/or professionals, so the number of requirements placed on specific organisations actually exceeded the sum total of recommendations identified in Table Two above. This presentation of recommendations may create

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difficulties subsequently in terms of measuring the degree to which individual agencies, and their staff, had completed the required actions. Similarly, some executive summaries and overview reports referred to independent management reviews prepared by individual agencies to inform the SCR. These reviews, not in the public domain, were said to contain recommendations for the relevant individual agency. Thus, some SCRs restricted their focus and commentary to recommendations for the LSAB and the multi-agency network responsible for adult safeguarding policy and practice.

Only 15 SCRs (47%) contained action plans, reflecting an observation by Manthorpe and Martineau (2011) with respect to their sample. Questions arise as to how specific, measurable and achievable recommendations will prove when it is unclear how LSABs will monitor their implementation.

Table 3: Layer Three – Frequency of Recommendations to Agencies

Recommendations for	Number of SCRs (n=32)	Percentage of SCRs (n=32)
LSAB and partners	26	81%
Adult Social Care	22	69%
Unclear/Unnamed Staff or Agency	22	69%
NHS Commissioning	14	44%
Housing	9	28%
Hospitals	7	22%
Mental Health Services	7	22%
Police	6	19%
Community Health	6	19%
Unspecified Health Agencies	5	16%
GPs	5	16%
Fire Services	4	13%
Out of Hours Services	3	9%
Ambulance Services	3	9%
Independent/Private Providers	2	6%
Voluntary Sector	2	6%
Legal Services	1	3%
CQC	1	3%
Children's Social Care	1	3%
Probation	1	3%
Crown Prosecution Service	1	3%

Layer four: themes within the recommendations

Table Four identifies the frequency with which individual recommendations addressed particular aspects of working with adults who self-neglect. These fall into broad categories relating to procedures, best practice, SCR process, and staff training and support.

A number of familiar issues are represented amongst the recommendations, notably information-sharing and working together. Considerable reliance appears placed on training and on development of guidance, when research (for example, Preston-Shoot, 2001; Campbell and Chamberlin, 2012)

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would question the degree to which either is prominent in influencing practice and its management. Several of the recommendations – case management (n = 20), recording (n = 18), supervision (n = 15), referral and assessment (n = 23), professional roles and responsibilities (n = 11) and using the SCR (n = 14) – attest to the uncertainty about how to manage the complexities presented by cases of adults who self-neglect. This is reinforced by the number of recommendations that advise on best practice with service users (n = 15), including those who are hard to engage (n = 15), and with family members (n = 13). The importance of legal literacy is represented in recommendations relating to mental capacity and to accessing and using knowledge of the legal rules, for example the Mental Capacity Act 2005.

The number of recommendations relating to the process of producing SCRs highlights the difficulties encountered by some LSABs in the absence of a statutory duty on partner agencies to co-operate and to share information, a gap in the legal rules in England and Wales that the Care Act 2014l remedies for the future. Manthorpe and Martineau (2011) also found in their sample problems being reported regarding the process of completing SCRs.

The extent to which the recommendations coalesce around key issues relating to best practice reflects findings elsewhere. Brown (2009) found that missed appointments were not being followed up and that assumptions were being made about mental capacity. Manthorpe and Martineau (2011; 2012) found recommendations that pointed to: a lack of awareness of procedures; failure to share information, which meant that agencies did not have a complete picture of the case; poor recording of assessments, including of mental capacity; and limited staff development through supervision and training.

Table 4: Layer Four – Types of Recommendations

Type of Recommendation	**Number of SCRs (n = 32)**	**Percentage of SCRs (n = 32)**
Training (Staff support)	27	84%
Develop, review & disseminate guidance (Procedures)	24	75%
Referral & assessment of need & risk (Procedures)	23	72%
Case management (Procedures)	20	63%
Recording & file/data management (Procedures)	18	56%
Mental capacity (Best practice)	16	50%
Best practice with service users, including person-centred, relationship-based approaches (Best practice)	15	47%
Hard to engage service users, including missed appointments (Best practice)	15	47%
Supervision (Staff support)	15	47%
Create & monitor action plan (SCR process)	15	47%
Co-ordinating services & working together (Procedures)	15	47%
Management of IMRs and SCRs (SCR process)	15	47%
Using this SCR (SCR process)	14	44%
Family, carer and resident involvement (Best practice)	13	41%
Information-sharing (Procedures)	12	38%
Professional roles & responsibilities, including escalation of	11	34%

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concerns (Procedures)		
Case file audit and quality assurance (Procedures)	11	34%
Awareness raising, for example of fire hazards, hate crime, poverty & self-neglect (Procedures)	10	31%
Accessing & using legal knowledge (Best practice)	6	19%
Contract compliance (Best practice)	6	19%
Hospital admission, care & discharge (Best practice)	5	16%
Disabled children and transition (Best practice)	2	6%
Staff health & safety (Staff support)	2	6%
Aids & adaptations (Best practice)	1	3%
Role of utility companies (Best practice)	1	3%

Five recommendations arising from a case for which the SCR is not in the public domain, but which have been presented at conferences (Williams 2010), are similar to those reported above, namely that policies should be reviewed to reinforce best practice regarding service refusal and to consider the place of self-neglect within safeguarding procedures, lessons from the SCR should be shared, an escalation policy should be developed, and training and awareness-raising concerning self-neglect should be undertaken. Two other unpublished SCRs on which presentations have been given (Slay, 2010) reinforced the importance of discussing complex self-neglect cases in supervision and in multi-agency meetings in order to develop a shared and planned approach. Case management also should include recording all efforts and actions taken, whilst best practice should involve providing service users with a written record of what has been offered and why, and what has been refused and how staff involved have explored this response. Best practice also includes involving the service user and discussing their views, providing information and exploring their choices in detail. This forms part of a comprehensive assessment that, where appropriate, also involves family members and the service user's social networks.

Cross-case thematic analysis of SCR recommendations

Cross-referenced to the four domains of the analytic framework, far fewer recommendations relate to the adult and their family/carer context, and to the team around the adult-in-situation, than to the organisations around the team and the LSAB holding the agencies in view. Table Four shows the same trend, with four of top six types of recommendations foregrounding procedures. This may reflect LSAB governance responsibilities, namely to set the parameters for, and then audit and refine, multi-agency policy and practice. Equally, it may indicate recognition that self-neglect has itself been neglected in policy and practice terms by LSABs and their partner agencies. Alternatively, it may betray reliance on a procedural approach to performance management. Findings on SCR recommendations follow; further detail on the complex situations described in the reports, including practice challenges and approaches, is included in a companion paper (Braye et al, submitted).

Adult

Nineteen SCRs recommend a person-centred approach, which comprises: proactive rather than reactive engagement; attention to cultural, language and communication needs; and foregrounding

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service users' wishes, views, experiences and needs. When faced with service refusal, there should be fuller exploration of what may appear a lifestyle choice and of the outcomes the person wishes to achieve (see also Scourfield, 2010). Contact should also be maintained, rather than the case closed, so that trust can be built and changes in motivation and in recognition of the need for help can be followed up (see also Braye et al., 2014). Nineteen SCRs also consider the individual's household, family and carers, with recommendations that carers must not be neglected in assessments and care planning, and that the dynamics between family members should be explored because they may underpin the self-neglect and profoundly influence a person's decision-making.

Fifteen SCRs focus on the difficulties of securing engagement, leading to recommendations that failing to co-operate should not be reason to close a case or reject re-referrals. Certainly, a risk assessment should be conducted prior to any termination of involvement, coupled with investigation of what might lie behind refusal to accept care. Thus, practice should avoid generalised assumptions and respond to each person's history, levels of risk and mental capacity. Loss, family history and trauma not infrequently lie behind refusals to engage, yet little has often been known about adults who self-neglect (Williams, 2010; Braye et al., 2014). Equally, practitioners should explore termination of contact to ensure that this is not the result of undue influence by others or inadequate information (Flynn, 2007), and that the effects of biography, chronology, history and context on the decision are understood (Manthorpe and Martineau, 2013). A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and acceptance, and relationship-building skills (Braye et al., 2014).

Fourteen SCRs identify mental capacity as a crucial issue – whether levels of knowledge of legislation (Mental Capacity Act 2005) and procedures, or the thoroughness with which assessments are completed and reviewed. Recommendations include the need to provide guidance for staff working with people who have capacity but engage in behaviours that place themselves or others at risk of harm, and recording of capacity at the point of service refusal. Such work may require practitioners to challenge their own assumptions about lifestyle choice and capacity (Braye et al., 2014), and the impact of the powerful ethical force of the statutory Mental Capacity Act 2005 assumption of capacity and associated notions of autonomy (Keywood, 2010).

Team around the adult

Interagency communication and collaboration feature prominently in SCR recommendations (n=22/32). Collective responsibility, a robust multi-agency approach to identification, assessment and management of needs and risks, together with a culture that encourages constructive challenge and debate, are all emphasised. This approach includes appointment of a lead professional to coordinate multi-agency contributions to need and risk assessment, care planning and reviews. Also recommended is the use of panels or meetings where agencies, regardless of who is currently involved, come together to use their specialist contribution to mitigate risks and to coordinate action. One SCR supplements this with a recommendation that agencies should provide a confidential written submission to any decision-making meeting that cannot be attended. Another SCR

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recommends that such panels maintain a multi-agency chronology so that isolated occurrences can be seen cumulatively and prompt action.

Central to interagency communication is information-sharing and 14 SCRs make recommendations to promote coordination of information around known risks. Thus, sustained, formalised and structured information-sharing across all agencies is needed to achieve shared understanding. That requires accurate recording (n=19/32) which should be contemporaneous and agreed by the professionals involved so that the potential is removed for discrepancies over what has been discussed and agreed. Dual recording is recommended where there is more than one database, to ensure that professionals have access to all available information.

Safeguarding literacy (n=20/32) and legal literacy (n=11/32) also feature prominently. Apparent failures to understand and use available legislation and to invoke safeguarding procedures lead to recommendations that managers ensure all staff have an awareness and understanding of raising alerts regarding safeguarding risks and of different areas of legislation, in order to achieve safe outcomes and protect service users' human rights. Legal advice should be available to support their decision-making. Lastly, recommendations foreground good practice by focusing on the quality of assessments, care planning and reviews (n=19/32). This includes the importance of follow-up and feedback to referrers, the development of standards for assessment and planning, and continuity of personnel through reassessment and reviews of action plans over time. Assessments should consider and document the relevance of mental health and mental capacity legislation, carers' needs and circumstances, and other legal options. Templates could be adopted to record assessment of need and risks, and what decisions were taken and why at safeguarding meetings.

These recommendations are further attempts to clarify the contribution of different agencies and professionals (Brown, 2009), ensure up-to-date records and information-sharing, and avoid narrow departmentalism or silo working (Parry, 2013), and enable practitioners to appreciate the potential rather than be confounded by the complexity of diverse legal mandates (Braye et al., 2013).

Organisations around the team

Supervision and management dominate this domain (n=17/32), covering staff support and managerial case oversight. Working with resistance, often passive and aggressive, can be difficult for staff and derail decision-making (Williams, 2010). Thus, recommendations foreground robust policies and systems for supervision and staff support across the agencies involved, including guidance that sets out expectations of managers in overseeing self-neglect work. Case oversight includes senior managers auditing cases, scrutiny and challenge of decision-making, and problem-solving in the multi-agency network. In complex cases, SCRs recommend real-time management of risk in working with people who refuse services and their inclusion on the agenda of risk panels.

Five SCRs address staffing issues, with recommendations covering co-working of complex cases and the allocation of self-neglect work to experienced workers with sufficient training, qualifications and resilience. Five refer to organisational culture and recommend moving away from eligibility-based,

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care management approaches towards adoption of person-centred and relationship-based principles that include engagement with need and risk. Six make recommendations for devising or updating organisational policies or tools, for example for assessing capacity, managing violence and aggression, recording referrals and action taken, and working with adults who have capacity but are at risk. These recommendations are in line with research recommendations (Braye et al., 2011; 2013; 2014) on workforce and workplace development, and effective agency oversight of self-neglect work.

LSAB around the organisations

The process of conducting SCRs did not always run smoothly. There are criticisms of undue delay, uncertainty over the procedures to follow and the poor quality of reviews by individual agencies of their involvement. Twenty SCRs make recommendations concerning devising or updating protocols for SCR management, training for report writers, and avoidance of delay in publishing findings. They also recommend the use of SCRs in training. Implementation of the Care Act 2014 may provide added impetus here, with its commitment to safeguarding adult reviews as part of a learning and improvement framework. Some SCRs had already triggered policy and practice refinements, for example in relation to fire hazards and utility company disconnections.

Greater evidence of action planning was found than reported by Manthorpe and Martineau (2011). Eighteen SCRs ascribed to LSABs a role in holding agencies accountable for compliance with recommendations but also in taking forward specific actions, such as training provision, completion of audits and the development of policies on sharing information or working with adults who have capacity but are at significant risk of harm. Nineteen SCRs propose training either on self-neglect itself or on a range of topics, including law, mental capacity, substance misuse, and fire risks, with some observing that there should be audits of take-up and outcomes.

Considerable faith is placed in procedures and guidance (n=23/32) despite evidence in the SCRs that practitioners and managers have failed to follow already agreed policies. Recommendations cover various topics, depending on the circumstances of the reviewed case, including fire risk and self-neglect, dual diagnosis, risk management, service refusal and disengagement, and information-sharing. However, whilst procedures and guidance may provide frameworks for practice and raise awareness, their implementation can be derailed by policy overload, lack of joint working, workload demands, staff turnover and limited knowledge and understanding of policy intentions. Simply having a procedure does not ensure that people are safeguarded, because knowing that a policy exists is different from developing an understanding of its content (Northway et al., 2007). Consequently, a focus on workforce and workplace development, where the former emphasises the provision of training and supervision and the latter how organisational and inter-agency cultures and systems affect practice, is necessary (Braye et al., 2013).

Conclusions

Some key considerations emerge from the foregoing analysis. First, what can be learnt from SCRs undertaken in cases of self-neglect? Aylett (2008) has suggested that there are no new messages to

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be communicated but nonetheless powerful lessons to be learned. Whilst the findings and recommendations within these SCRs are gradually becoming repetitive, they are contributing to the creation of an evidence-base for working with adults who self-neglect. Moreover, evidence suggests that self-neglect SCRs have acted as a trigger for policy and practice development within and beyond the local authorities where they have been commissioned (Braye et al., 2014).

Some commentators (Scourfield, 2010; Manthorpe and Martineau, 2013) have suggested that the publication of executive summaries rather than full reports limits understanding of what may have happened and therefore the learning to be disseminated. Whilst the quality of the reports reviewed here is highly variable, nonetheless the best provide sufficient detail to realise Brown's (2009) aspirations for SCRs, namely that they can enhance service development by identifying policy and practice loopholes, and improve service delivery by highlighting the knowledge and skills required of frontline practitioners and their managers. Others have criticised SCRs for being overly descriptive, observing that for learning to inform policy and practice, reports must explore the contexts – legal, ethical and organisational – within which people took decisions (Flynn et al., 2011). It does appear that SCRs are better at answering the question "what took place?" than exploring "why" questions – the underlying reasons behind omissions or decisions.

Second, how can the learning be effectively disseminated? Aylett (2008) bemoaned the absence of a coherent strategy for the dissemination of learning from SCRs. Parry (2013) concluded that lessons were rarely disseminated. The difficulty of obtaining SCRs on self-neglect (or indeed on any other sub-set of specific issues under scrutiny) lends weight to calls (Brown, 2009; Braye et al., 2011; Flynn et al., 2011, Manthorpe and Martineau, 2011) for a database of adult safeguarding SCRs in order to enhance learning and improvement and to inform legislative and policy development driven by real cases. In Scotland, Adult Protection Committees, whose functions are similar to LSABs in England and Wales, have been disseminating SCRs and inquiry outcomes for learning and improvement (Cornish and Preston-Shoot, 2013). While evaluation of the impact of adult protection training has been limited (Campbell and Chamberlin, 2012) and it is by no means the case that training interventions inevitably lead to improvements in practice (Pike et al. 2010), educational sessions have been found to be more effective than printed material in increasing people's knowledge and case management skills (Richardson et al., 2002). Where these can include case material such as that drawn from consolidated findings of SCRs the potential for impact is arguably stronger. One recent study (Braye et al., 2014) has found that SCRs were used to raise awareness and knowledge of self-neglect, and to build a skills inventory for working with such cases.

Third, SCR recommendations add to the growing body of knowledge about effective interventions in cases of self-neglect. As research (Braye et al., 2014) confirms, a multi-disciplinary approach is required, informed by skilled and timely capacity assessments, understanding of available legal rules, training and supervision that challenges and supports. Care by consent is preferable, with relationship-building tuned to the unique experiences of each individual who self-neglects. The SCRs lend weight to the importance of operating within detailed guidance, with multi-agency work co-ordinated by a lead manager, and of providing opportunities, such as network meetings and panels,

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so that different value positions regarding autonomy, self-determination, duty of care and promotion of dignity can be debated and then navigated in the context of specific cases.

Overall, these SCRs illustrate the complexity of practice with adults who self-neglect and provide a rich source of learning for those involved in all forms of adult safeguarding. The frequency with which LSABs have felt it necessary to inquire into the outcome of cases of adults who self-neglect, and to develop procedures in response, coupled with the developing evidence-base about effective management and governance of practice in this field, suggests strongly the value of self-neglect being included in statutory guidance on safeguarding to support implementation of the Care Act 2014.

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[i] Where cases do not meet the criteria for an SCR, LSABs may commission other types of single or multi-agency review. They may conclude with recommendations and action plans. Generally, they are not published.